HOUSE OF COMMONS

Environment, Food and Rural Affairs Committee

Oral evidence: Rural mental health, HC 873

Tuesday 26 April 2022

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Watch the meeting

Members present: Neil Parris (Chair); Kirsty Blackman; Ian Byrne; Rosie Duffield; Barry Gardiner; Dr Neil Hudson; Mrs Sheryll Murray.

Questions 51 - 124

Witnesses

I: Melanie Costas, Founder and Chief Executive, Rural Mental Health Matters; and Barbara Piranty, CEO of Gloucestershire Rural Community Council.

II: Dan Mobbs, Chief Executive, Mancroft Advice Project; and Karen Black, CEO, Off the Record.

III: Dr Jude McCann, CEO, Farming Community Network (FCN); and Alicia Chivers, Chief Executive, Royal Agricultural Benevolent Institution (RABI).

IIII: James Russell, Senior Vice President, British Veterinary Association (BVA); and Dr Rosie Allister, Vetlife Helpline.

Written evidence from witnesses:

– Farming Community Network

Examination of witnesses

Witnesses: Melanie Costas and Barbara Piranty.

Q51 **Chair:** Welcome to the Environment, Food and Rural Affairs Select Committee. Today we are looking into rural mental health and we are very fortunate to have some good panellists before us. Melanie Costas, would you like to introduce yourself for the record, please?

Melanie Costas: I am Melanie Costas. I am the founder and CEO of Rural Mental Health Matters, a social enterprise. Our focus is on tackling rural mental health inequalities. We do this by supporting other organisations from planning stages to delivery so they can make their services rurally inclusive. We also look at delivering projects on early intervention and mental health awareness in rural and remote communities.

Chair: Thank you; and Barbara Piranty, please.

Barbara Piranty: Good afternoon. My name is Barbara Piranty. I am CEO of Gloucestershire Rural Community Council, which is part of the ACRE Network of communities in rural England. We are one of 38 rural community councils and we are the third oldest in the country. Our remit is to support communities to enable them to remain sustainable. We are an enabler. We cover everything from affordable housing through to young people and older people, village halls and parish councils. We are all-inclusive.

Chair: Thank you. That is the bell. In a way, it is probably that it happened now rather than when you were in the middle of your evidence. If you don't mind being patient, we will be back as soon as we can.

Sitting suspended.

On resuming—

Q52 **Chair:** We are back in session now. There do not appear to be any more votes for quite a while so hopefully we will not be disturbed again. Melanie and Barbara, we will just carry on. You have introduced yourselves so I will come in now with the first question. It is a fairly broad one: what are the key mental health challenges facing people in the rural areas that you work in? Who would like to start?

Barbara Piranty: The list is quite long, and I am sure there is overlap with what Melanie will talk about.

Access and transport are really high on the list—access to emergency or specialist services, GP appointments or just general support services—and I think it is well documented that transport is practically non-existent in rural areas due to costs. Digital exclusion is another area. People are excluded either by lack of availability of broadband, or speed, and some people cannot afford to be online or do not want to be—they simply do not want to be, so they are excluded in that way.

Other challenges include wait times for mental health support, local activities and early intervention. Early intervention is key for mental health, but support all seems to be at the crisis end so more needs to be done, particularly around the voluntary, community and social enterprise organisations. Social isolation and loneliness have increased, exacerbated by Covid. Food and fuel poverty is a more recent issue that is getting worse by the day and is affecting the most vulnerable in our communities.

There is also flooding due to climate change and adverse weather events, unemployment and underemployment—people not being able to stay in the communities where they grew up—and of course there is also the stigma around mental health. When you are in a rural area, and you are known, it is very difficult and still very much misunderstood and a lot of education needs to happen. I do not want to hog the limelight so I will hand over to Melanie Costas.

Chair: Thank you. Melanie, would you like to add anything?

Melanie Costas: I agree with everything that Barbara said, her key points. I would like to add long journey times and multiple different routes. For example, in north Dorset, to get to services in the south of the county, you would be talking about three or four bus changes. You might be able to get to an appointment but not be able to get home.

Visibility is probably the main thing. What I mean by that is people's perception; if they do not see services in their community, they believe that they are non-existent. That can lead to a sort of stoicism and self-reliance and then people only tend to present in a crisis. Seeking support earlier is a key challenge because of those issues.

Q53 **Chair:** Are people trying to get to an appointment very often relying on friends or neighbours or a charity to get them there? Is there a charitable organisation running any sort of service in all areas?

Melanie Costas: There are services, but "only those in the know, know"; that is what we say. Only if you know that the services exist can you call on them. Generally, people do not know about those things, so they tend to think they will drive themselves, or they may not feel well enough to drive, because if they are facing a long journey and not very well mentally—

Q54 **Chair:** People are stressed anyway, aren't they, before they go for an appointment?

Melanie Costas: Exactly, so the added stress of facing a long journey and then, as Barbara said, longer wait times because of the stress on the services.

Barbara Piranty: For community transport providers and volunteer drivers there is also the cost of fuel, which is causing no end of problems, and volunteer drivers may be more fearful of taking passengers. Covid still has a huge impact on people's fear about re-engaging.

There are a couple more things. The ageing population is another serious issue because people are ageing faster and in rural areas that is where the concentration is going forward. Workforce retention and recruitment are problems, particularly in social care. All those things are impacting mental health.

Q55 **Mrs Sheryll Murray:** Could you let me know if you think that being in a rural community means people face different mental health challenges compared with urban communities? You mentioned transport. Do you have any information about the impact the community buses that were provided by the Government a few years ago have made? I have quite a few in my constituency and I think they are based all over the country. Could you give us some feedback on them?

Melanie Costas: It is very difficult to provide them in counties that are predominantly 50:50 rurality. We are based in Dorset where 46% of the population live in rural or remote areas. It is quite a lot, so to provide that for that whole rural area is quite difficult. I don't know of the service you are talking about in North Dorset. It is volunteers in the community who help out.

Q56 **Mrs Sheryll Murray:** Do you not have any community buses under the Department for Transport scheme?

Melanie Costas: Not that I am aware of.

Mrs Sheryll Murray: I think you will probably find that there is.

Melanie Costas: If I don't know about them, imagine how it is for other people who don't know about them. There is definitely nothing publicised. I do know that the cost of public transport is a major factor. For example, if somebody is living 5 miles away from Gillingham or Shaftesbury—they are border towns—it costs up to £5 each way on the bus. That is quite a lot of money out of their budget for somebody from Gillingham to access mental health services in Shaftesbury. We do have some community transport, but it is very thin on the ground. As far as I am aware, we do not have community buses.

Mrs Sheryll Murray: These are the mini-buses.

Melanie Costas: Yes.

Barbara Piranty: I know Gloucestershire is currently procuring a demand-responsive service for some of the more remote rural areas, but then there is the question of whether it is a viable option once it is put in place. If the service is not used enough it is not financially viable, which is half of the problem with rural transport. Running a service is very costly if you only have two or three people at a time wanting to go somewhere on a bus. It is a chicken-and-egg problem. However, I do know they are putting demand-responsive services into the Forest of Dean and the Cotswolds, which I hope will be a little bit more useful for residents because it will take them to the arterial routes, but the problem is within the district.

Q57 **Mrs Sheryll Murray:** Could expand on that? Do you think that being in a rural community means that you face different mental health challenges compared with urban communities?

Melanie Costas: With public transport, for example, in 2017 there was a review—

Mrs Sheryll Murray: Not necessarily with public transport but in other areas.

Melanie Costas: Yes, because there is no infrastructure and the roads are difficult.

Mrs Sheryll Murray: Could you expand on that? I am trying to find out whether there are other challenges in a rural area compared with an urban area, for example access to services; perhaps access is easier for some. I don't want to be accused of leading you as witnesses, but could you perhaps expand away from transport. Are there any other challenging areas?

Melanie Costas: Yes, there are. People are encouraged, which is great, by mental health awareness campaigns to reach out—it's okay not to be okay—but when they do reach out, they often find that they do not meet the eligibility criteria and then there tends to be nothing else; they are just left. If they do meet the eligibility criteria, they find they are on a waiting list for quite some time. That is also an issue facing people in rural areas because most of the services tend to be in the urban areas.

An example from the county that I live in: there are two retreats in Dorset. A retreat is somewhere you can go if you are starting to feel unwell. They are run by peer support workers, the NHS and trained mental health workers and mental health first aiders. That is great. One of them is in Bournemouth; the other is in Dorchester, so very much a north/south divide. It is the same with in-patient beds with one service in Dorchester and the other in Poole.

Chair: We are going on to talk about that.

Melanie Costas: Yes. It is difficult for people in rural areas to get there. They might be able to get to an appointment but they cannot get home again. Also, the travel times are longer because we tend to have single-lane roads. There are no motorways.

Chair: I do know the roads in Dorset so, yes, I understand.

Q58 **Mrs Sheryll Murray:** Do you have anything to add, Barbara, before we move on?

Barbara Piranty: Yes. Part of the problem with a rural area is that you have so much further to travel to get to the services you need. That is exacerbated if you are somebody who suffers domestic abuse or you are a carer in a rural area, and with Covid you are trapped in an environment where there is nothing to go to.

We know that during Covid there was a problem with accessing good quality food. If you were in lockdown and were not able to travel, your only option was maybe your corner shop, your village shop, which may only stock dry or tinned food.

Part of the problem is that the very things that you need are not close at hand, so it is either travel that is causing the problem or the services are just not there. That is why it is very important to use the VCS more effectively to be able to provide the support services and early intervention that health services are not able to provide at the moment for whatever reason.

Q59 **Ian Byrne:** I will build on what we have spoken about and go first to Barbara: do you think NHS mental health services in your areas meet the needs of your communities?

Barbara Piranty: That is not an easy question. I think there is a willingness. Looking at Gloucester, for instance, and the statutory services provided there, there is a plethora of services available. The problem is wait times and reduced capacity. You have a workforce on its knees. You have people off with stress and some people have left the profession. I keep going back to Covid, but that has decimated so many services. We know that there is an issue with retention so, even if you can recruit, retaining staff is a problem.

I was working in digital mental health for four years during Covid, and that was an eye-opener. We found that many people coming on to digital were doing so because they had waited and waited to be seen and then, when they were seen, were told they did not meet the criteria. The problem is that thresholds have been raised and criteria are tighter so people are left with nowhere to go.

Q60 **Ian Byrne:** The picture you are painting: are you saying that was the same before Covid? Obviously Covid has made it worse, but where were the beginnings of it?

Barbara Piranty: Covid has made it a lot worse. We know that from the acute wait times for surgery. Mental health demand has increased so steeply since Covid. We know the problems are happening now—they were bad during Covid, but we are going to be seeing this for years to come. The Centre for Mental Health has already said that people experiencing trauma, bereavement and loss may only present later down the line, as will the workforce that has been working through it.

Q61 **Ian Byrne:** Is there a difference in impact in rural areas compared with urban areas?

Barbara Piranty: For the same reasons, because it is about access and the difficulty with access. You have to travel so much further. In statutory services, there is an expectation that you will travel to central points, and that could be 30 miles away. If you are on a low income, you have no access to a car and buses are infrequent, you have no chance. People were very good and stuck to the rules by not going to GPs during Covid,

so the problems are stacking up now and there is nowhere for them to go.

Melanie Costas: Historically, funding for NHS mental services and support has tended to be primarily focused on crisis intervention. Planning is according to need and focuses on the highest percentage of those who are registered with serious mental illness, SMI, so the services tend to be where those people who are registered are and they are about crisis intervention.

In our opinion, this creates a Catch-22 because only those who have been diagnosed or have had previous knowledge are aware of how the system works. It has often been mentioned to us—and I have said this before—that only those in the know, know where to go. Because budgets are so tight, the NHS looks at the more serious and more diagnosed cases and places services accordingly.

That happened when the consultation on the acute mental health pathways proposals was done in 2017; 66% of Dorset's mental health services were put in the areas where people were registered on the serious mental illness register. So, what happened to the 34%? Barbara has mentioned the eligibility criteria. There is nothing in place that signposts people and supports them when they are on a waiting list or if they are not eligible; they are left in limbo. That is not meeting anybody's needs.

Q62 **Ian Byrne:** Building on that, the Mental Health Implementation Plan for the NHS, the long-term plan, was published in 2019. Sarah Hughes, CEO of CFMH said in one of our previous sessions, "—our long-term plan does not really refer to rural populations clearly enough to understand what the needs are exactly". Now we have gone through Covid, learnt the lessons and seen where we are, the situation you are outlining, does that plan need to be reviewed?

Melanie Costas: Yes, I think so. I also think that physical health and mental health need to be reviewed together. As we often say, you don't take your head off when you go to an appointment about your arm, but nobody seems to be asking those questions. I don't think that there is training in clinical settings—GPs, nurses—about mental health. For example, I am disabled and I have had issues with my back going on since 2008 and I have been asked just twice about my mental health. If somebody is in pain or is a carer, they need to be looked at holistically and I don't think we are anywhere near there. We talk about parity of esteem but I don't think we are anywhere near that.

I think the NHS services could have VCSE embedded within them, perhaps a triage system in each of the primary care networks at ground and community level where, instead of people who do not fit the criteria being told they are not ill enough to get support—because that is what they are really saying, "You are not ill enough"—VCSE people in the same team could say, "Do you know there is a peer support group?" or, "Do

you know you can pop into the library for wellbeing chats and a cup of tea?" and so on.

There is often support in the community, but clinicians are very much focused on diagnosis and treatment criteria. For them, it must be like trying to keep an encyclopaedia in their heads and they cannot do that. The VCSE could do it, so it would help if they were incorporated into the clinical side of things.

Q63 **Ian Byrne:** Building on that, how do we ensure that people who need access to treatment will get it as soon as they need it in the rural areas you are talking about, given the cost of living crisis, the price of petrol, Covid and everything? How can we ensure we reach out to everybody in rural communities and provide fair opportunities for treatment?

Melanie Costas: Recently, Jim Hume from the National Rural Mental Health Forum in Scotland did a piece of work on people living in so-called deprived areas. We have an index of deprived areas and that is another thing; things are weighted for those deprived areas. Jim Hume found that two-thirds of the people who responded to the survey, and who were living with quite a high level of deprivation, did not live in the indexed areas. That was interesting. Jim Hume says that it is people who are deprived not places, so we need to rejig that.

It is the same with serious mental illness and people on the register; we need to look at them more broadly. In the NHS we are quite set up, and have been for quite a long time, in physical and mental health, to treat people at the crisis stage, and it would be better if we could intervene earlier. Some people do not recognise that they have an issue until they have a major breakdown or something traumatic happens in their lives, but the signs might have been there earlier and, if they knew that they could go somewhere earlier, they might be more well mentally.

Q64 **Ian Byrne:** Would you like to add anything, Barbara?

Barbara Piranty: We know that many people who present at the GP do not have a medical problem. Often they have early signs of mental health issues. They could be around finance or housing and so on. That is where social prescribing comes in and that is such an important role, demedicalising. The problem is that we have a clinical biomedical model that needs to be more of a social impact model.

It is said that there is no physical health without mental health; physical and mental health should be combined and treated as one service but they are not, which is half the problem. The All-Party Parliamentary Group on Mental Health inquiry covered all these issues only a few months back. It made some very strong recommendations about the way data is collected within the NHS, which does not reflect, and is not fit for purpose for, rural areas. Many recommendations came out of that inquiry. One was about the call to action for the urban/rural divide and making a real difference.

Ian Byrne: Thank you.

Chair: We will take heed of that

Q65 **Barry Gardiner:** Thank you for all that you have said. This inquiry is about rural mental health, quite specifically, and that means that we are trying to distinguish rural from non-rural. I am an urban MP—I declare my interests—but I was one of the people who called for this inquiry because I think it is very important that we get to the bottom of it.

We can talk about the causes and you have done that: the causes of anxiety and stress that lead to people having problems with their mental health. Much of what you have said about the causes of anxiety and stress—work, poverty and deprivation—are common to the urban context as well as the rural context. It seems to me that one of the things that you have highlighted as being different is access and transportation.

What I wanted to do here, Melanie, was pick up something that you said in your submissions. You said that people did not feel that they can be open about their mental health and wellbeing in their community, and I think, Barbara, you talked about stigma. You also called in your submission for a mobile outreach, something physically in the local village so that you could overcome the problems of access and transport, but there is a tension here, isn't there? If there is a local van that comes round once a week or stays there for a week, everybody in the village will be saying, "Oh, I wonder who's going into the van?" How does that work?

Melanie Costas: I understand why you say that and some mobile outreach services do do that. For example, in Wales there is a service by one of their Mind organisations and it is a bright yellow vehicle. This is one of mine, in fact, so sorry about this. There is a guy dressed up in a banana. People who want to support Mind and know about Mind will go to that van. However, what we talk about when we talk about mobile outreach is more of a café and a chat kind of outreach rather than something clinical, because that would not work. We don't talk about an outreach—

Barry Gardiner: It is not mobile outreach—

Melanie Costas: Well yes, the "mobile" means low cost because it is too expensive to put a service in every single town and village rurally. A 10-year study in rural Greece finished in 2017. It took community mental health teams out to the community. That has not happened here since the 1980s. They are all stuck in offices somewhere, above GP surgeries for example, and they only deal with crises—

Q66 **Barry Gardiner:** Explain to me. They would go to a village hall and have a coffee session there?

Melanie Costas: We did a pilot last year called "Socially connecting Shaftesbury". The words "mental health" were not in there. The blurb was "All things mental health and wellbeing". That was because there is a stigma, I agree. We had people come in and see us, people who had never been anywhere before because they found it open and welcoming. They could come. We had other stakeholders there at different times. We

had carer support; we had the CCG; we had lots of different organisations at different times throughout the pilot. It was just a safe, accessible place where people could come in and have a cup of tea.

That conversation can lead to things. Some people said, "Mental health? That's not me". We said, "Would you like a cup of tea while you're waiting for your bus?" "Yes." While you are sitting there talking to them, things come out. That is the kind of outreach we are talking about, much earlier intervention. We are not talking about going out with clinical intervention—well, maybe down the line—but we are talking about raising awareness.

That would break down stigma because when people don't see a service or anything in their communities, they believe that there isn't anything. As you know, mental illness is already an invisible illness, made more invisible by nothing in the community. There need to be more things in settings where people go every day. We have libraries up and down the country. We could make use of those, which would be great. One of my directors does Wellbeing Wednesdays in Sherborne libraries and that is really well attended.

Q67 **Barry Gardiner:** If we were looking at the key things that would make a difference to mental health in rural areas, you would say that one of those is having those local hubs where every month or every week, or whatever it is, there is some form of outreach but that it is normalised within the community?

Melanie Costas: Absolutely. That is the key to breaking down the stigma.

Q68 **Barry Gardiner:** Are there any other sorts of interventions specific to the rural community that you think would be those key interventions? Barbara, you wanted to come in.

Barbara Piranty: You pose a very good question because the shame attached to mental ill health, along with the stigma, is a problem, particularly with men. They are told to "man up". The situation is much better now than it used to be, but there is still a problem.

I will give you an example of some of the great initiatives, the Lions Barber Collective. We know that men go and get their hair cut and, like women, may well chat to their barber about things that are going on in their lives. Having barbers upskilled to be able to provide signposting support to mental health services is important.

It is the same whether you are talking about dementia or general mental health issues. Outreach is about providing a space where people can come and find out general information. If I was having financial problems, for instance, the last thing I would want to do is go to my village hall where they were doing a session on finance because then all my neighbours would know I had a financial problem, so you would badge it as something else whether that is wellbeing or something general around tea and a chat.

Q69 **Barry Gardiner:** Tell me this. I am coming back to the fundamental question. All the things that you have talked about make perfect sense and make perfect sense to me in an urban setting. What are the uniquely rural things? What is uniquely rural about this? This is how we are trying to focus the investigation. I agree with all that you say. I can see that that would make a difference and putting those networks in place would be good, but is there any key intervention that you could make that would be specific to the rural context?

Melanie Costas: I think it is a bigger picture than that. When we talk about stigma, it is also in the workplace. Where you work in a rural community, if there is a big organisation that takes up the town—which generally does happen in rural areas, there is one big workplace—if you feel that you can ring in and say to your boss, "I cannot come in today because of my anxiety; I cannot leave the house" that is a big problem.

There need to be more mental health first aiders. I do not understand why we have physical first aid in the workplace in law but do not have mental health first aiders. If somebody has an accident at work or witnesses an accident at work, it can have a detrimental effect on their mental health—PTSD, all sorts of things. People can be signed off for a long time with stress, but there is no support there for their mental health. There is a combination of things: there is outreach, early intervention and mental health first aid. That as a whole would help in rural communities.

The most important thing that we have been told is that there isn't anything visible. There isn't anything visible and people just presume that it is all in the towns, the conurbations, which, let's face it, it is. People say, "There is nothing there; therefore, I won't speak up because nobody can help me". This is the stoicism of people living in rural areas and in certain professions. You will hear later from the vets and the farmers; those communities are very close-knit. Carers also have a tremendous amount of stress in their lives. What tends to happen is that their cared-for person may have an accident or go into hospital and then the carer breaks down.

Chair: Can we keep the answers a bit tighter? We are starting to run on. It is good evidence, but we have to keep it shorter.

Melanie Costas: There are fundamental issues: it is the visibility and the infrastructure.

Chair: Over to Barbara Piranty now. Then Sheryll Murray has one quick supplementary and after that it will be open to Neil Hudson.

Barbara Piranty: The difference in rural areas is the isolation. That is key. It is well documented now. It is one of the top issues through social prescribing. It trebled in Gloucester and the Cotswolds last year; it trebled as being the top presenting issue coming into the service. The problem is isolation and the centralisation of services. It is not financially

viable to run services in rural areas, so they are centralised and people are expected to come to those central points for access to services.

Also, youth services are non-existent rurally. Antisocial behaviour and mental health issues are off the scale among children and young people. Everything is exacerbated if you live in a rural area because you do not have access to what you need.

Chair: It is expensive to get people out. There used to be many more people coming to the farms and the rural businesses to sell things. They don't come there now. All sorts of things that used to happen don't happen now. Sheryll Murray, very quickly, please.

Q70 **Mrs Sheryll Murray:** A very quick question and a very short answer, please, or I will get into trouble. How would you fund mental health first aiders in the workplace? Would it be through the Government, the NHS, or do you envisage it being funded by employers?

Melanie Costas: How is first aid funded? It is funded by the employer, I believe. I don't see a difference. There could be blended courses. I know that there are subsidies and stuff like that.

Mrs Sheryll Murray: Thank you.

Chair: I think we will park that question there.

Q71 **Dr Neil Hudson:** I think you have covered a lot of my questions already so this is a final question, I guess a wish list for you both. What changes would you like to see in the way mental health services are planned and delivered? You have answered a lot about crisis versus prevention and outreach. In a very punchy way, could both of you give us a wish list of how you would like us, as a Committee, to recommend changes to the planning and delivery of mental health services?

Barbara Piranty: Recognise that mental health should sit within physical health services and not be separate. They are equally important. Without mental health, there is no physical health. There is a need for rural-proofing. That continues to be the message that does not seem to be getting through, as per the APGG report recommendations. Mental health messaging needs to be normalised and provide positive statements relating to mental wellbeing. It is important to let people know that it is okay if you are not okay.

Mental health education and early intervention should be increased in primary schools, because that is where the problems start and mental health issues are usually embedded before the age of 14. Community-based services around mental wellbeing, allowing the VCS to take the lead, because we are the experts in early intervention but we need to be funded, and not with short-term non-recurring funding but with sustainable funding to allow us to do that work and prevent crises.

There is a need for DEFRA to work more closely with the Department for Health and Social Care and, again, for parity within the data collection

within NHS around rural, and better and increased access to localised mental health support and the use of digital as an enabler, if possible. That is quite a long list.

Chair: A very good list.

Q72 **Dr Neil Hudson:** Your list, Melanie.

Melanie Costas: Barbara has gone over quite a lot. I would like to see that every support service from planning stages through to delivery was held accountable to ensure that their services and support are rurally inclusive. We often talk about people who are hard to reach, but they are not in a bunker somewhere in Derbyshire—sorry to talk about Derbyshire.

There needs to be a national body overseeing this, as there is in Scotland. The National Rural Mental Health Forum has succeeded in changing legislation and being the voice for people living in rural and remote communities.

We need to have the VCSE sector embedded in all healthcare settings, including mental health care settings, for signposting early intervention information and advice and that needs to be properly funded. A lot of the organisations are operating on a shoestring and rely, as we do as a social enterprise, on fundraising and grants. To work properly, we need a national body, properly funded and oversight and accountability.

Dr Neil Hudson: Thank you. That is very clear. There are some very good take-home messages for us.

Chair: Yes. Thank you, Neil, and thank you both very much for those really good ideas. I thank you both for being able to explain to us what you are doing and what you would like to see done better. It is always interesting when you have to get Government Departments to work more closely together. You talked about DEFRA and Health and even Education, all the things we need to pull together. Thank you very much. I hope it has not been too traumatic for you this afternoon.

You may stay and listen to the other evidence or go, whichever you wish to do. Thank you very much, Melanie Costas and Barbara Piranty.

Examination of witnesses

Witnesses: Dan Mobbs and Karen Black.

[*This evidence was taken by video conference*]

Q73 **Chair:** Further to the previous panel, I will ask you both to introduce yourselves. I will ask Dan Mobbs to introduce himself first and then come to Karen Black. Then we will enter into the questions.

Dan Mobbs: I am Dan Mobbs, the chief executive of Mancroft Advice Project, a youth organisation in Norfolk providing advice, counselling and youth work including in rural areas.

Karen Black: My name is Karen Black. I am the chief executive of Off the Record in Bristol. We deliver services across Bristol, South Gloucestershire and North Somerset for young people and their mental health and wellbeing.

Q74 **Chair:** Karen, I will ask you this question first and ask the same question of Dan next. What are the key mental health challenges facing young people in the rural areas you work in?

Karen Black: I have been listening to the last session and many of our issues will not be very different from what you have already talked about. Isolation is one of the key things and, therefore, we need to think about where to set services up and the accessibility of services is one of the key challenges: Where are they? Why would people want to go to where you are setting them up?

One of our big key challenges is the serious lack of infrastructure around young people, the absence of a youth sector in many ways in rural areas, or very small pockets of it. What you often end up with is young people presenting to services because they are in crisis because nothing has come before that, so the problems that we see in services are often much worse.

Planning is often one of the issues. I am probably straying into a different question but, going back to what I said around where do you put services, there are general issues of accessibility and accessible transport and issues around the diversity of equalities groups, particularly for young people who might be struggling with identity, gender, sexuality, the lack of access and the lack of local representation.

On top of all of that, there is the stigma and where parents can get the information to support young people. There are multiple factors, but isolation and, therefore, where services are to make them accessible is probably one of the biggest.

Q75 **Chair:** I expect you find that in rural areas people are inclined to say some people are "different" and I think that is probably the issue, isn't it? In some ways living in urban areas is not perfect, but you can probably be slightly lost in society, whereas the rural society does watch everybody, doesn't it? Do you find that to be an issue?

Karen Black: Yes, I think it is a different community focus. As you say, in urban areas young people often get lost and that in itself could be identified as an issue. Whereas young people are often on show and their families may not have access to support. The types of presentations that you see or the expectation about how they get resolved may be quite different.

Equally, we have set up quite a lot of services in schools, and that goes back to the point the previous speaker was making around setting things up in libraries. It works for lots of people but not for everybody because it is very exposing. It is a different issue in many ways. Although the fundamental presentation might be the same, where it is coming from is often quite different.

Q76 **Chair:** Thank you. Dan, please, the same question: the challenges facing mental health, the challenges facing young people in rural areas.

Dan Mobbs: The first thing to say is I agree with my colleagues and you are on to a win here because we are all saying exactly the same thing.

To answer that question, you need to speak to young people, and that is what young people have instructed me to tell you. There is an open invitation to visit Norfolk and speak to young people who have lots of views on mental health in rural areas. I know you have gone on trips before, so Norfolk awaits.

We also need to understand what we mean by mental health. When we talk about physical health we understand that there is hospital treatment and that we should do a bit more exercise; mental health is the same. There are people who are severely unwell in hospital and we all have bad days when we feel miserable. The difference is stigma; we don't always talk about why we are having a bad day and how we are feeling. It is about feeling. It is a strange term, "mental health". Mental is actually about how we are feeling, which is much harder to have conversations about, but for young people it is critical and we know that three-quarters of all mental health problems emerge before the age of 24.

Without repeating too much of what people have said, there are huge problems with waiting times for treatment, but there have been huge cuts to youth services in the last period—we know that £1 billion has been taken out of annual budgets—so neither of those two extremes is well supported.

People have talked about issues of inequality, and that applies particularly to transport in rural areas. If you are a young person it is a double whammy, because even if your household does have a car you are entirely dependent on your parents to take you. You were talking about community transport earlier. That is for eligible adults. It does not apply to young people. Again, that is a challenge.

If you do have public transport and you are lucky enough to have a bus that goes from your village to where there is support, an appointment can take you all day, as has already been said, and that is even harder for a young person. If your issue is anxiety or depression and it is hard to even do that in the first place, it is a double whammy. I do appreciate your focus on rural areas so keep trying to do this because there are massive similarities between the issues in urban areas and rural areas and we must not forget that.

Another thing we talk about a lot is how policy is decided in London and it does not necessarily apply to rural areas. A good example of that, or a bad example depending on how you look at it, a good example of it being a bad thing I should say, is the National Citizen Service. It is a very urban model because it involves people going and having some rural adventure outdoors. If you are growing up in the countryside there are advantages, low crime and the great outdoors. For some young people that is great, but they have probably had enough of it.

When you think of the economy locally, especially where we are in Norfolk, there are often employment opportunities in the holiday periods. That is the only time when there are employment opportunities because of seasonal employment. That is another effect on young people's mental health, the fact that the winters are long and the summers can be quite good.

Q77 **Chair:** I think probably what you are saying is that to many people the countryside looks delightful, the scenery is lovely, but when you are younger and growing up you probably want a little bit more excitement. Perhaps the policy should be written that they should be able to visit the urban areas to have some excitement if you see what I mean. I am not being facetious; it is the difference between the populations, isn't it?

Dan Mobbs: That is right and there is truth in that, but some young people do love where they live. A particular challenge then, and keeping it on the rural issue, is if you cannot see a future for yourself where you grow up because the jobs are not there, the housing is not there, especially in parts of Norfolk where people cannot see themselves affording a life there, that is also particularly bad for their mental health.

They are already thinking of where they can move to so they are already seeing the community that they might well love being not an option for them in the future. I completely agree with what Karen says; if you are from a particular minority group then that is even harder so you are looking to move out.

The stigma of everyone knowing you and if you are accessing mental health services, all those things I completely agree with.

Chair: I am in a very small rural area and you know exactly what is happening to everybody and I think that is an issue.

Q78 **Mrs Sheryll Murray:** Are you saying that the National Citizen Service is not available to people in rural areas?

Dan Mobbs: No, I am not saying that at all. I am saying it was designed with urban culture in mind and it is going through a change as you are probably aware and hopefully that is because they have been listening for the number of years we have been saying that this model does not work in our areas as well as it works in other areas. Young people still access it and gain a lot from it so I do not want you to think that I am completely anti it. It is just very much an example of an urban model.

Mrs Sheryll Murray: I remember going sailing with some young people who did not go very far from my own constituency and they all thought it was great because we capsized but yes, they do get some benefits from it.

Dan Mobbs: I agree with that.

Q79 **Ian Byrne:** We should take you up on that offer; we should go to Norfolk and visit the kids, we certainly should. As an inner-city MP, it is something I would be keen to do to see if their experience is the same.

I am delighted you raised the £1 billion taken off youth services, which has decimated youth services in my constituency. It is part of this question now. Sometimes in the inner-city areas we look at, as you have talked about, it is a different lifestyle and I do not think the difficulties for young adults in rural areas have been acknowledged.

Do you think being in a rural community means young people face different mental health challenges compared with those living in urban communities? It is good because you cover both, don't you?

Dan Mobbs: Absolutely, yes. Norwich is an urban area; a progressive city and it is in the middle of a huge rural area. It is difficult to answer that without repeating what has been said, to be honest. Isolation, as people have been saying, is a huge thing and there are different ways people are isolated—if they are in a minority group for example. Just the fact that they cannot get somewhere and they are stuck in their home and they are dependent on their family. Someone has already said this, but broadband connections can be really poor so even digital access is not very good.

We spend a lot of money on taxis to bring young people together because it is an important part of young people's development to spend time with each other, and that requires them to be able to get somewhere. Why that is particularly important is because when you are young it is a period of personal development and growth and trying to find a way for yourself and you need to do that on your own terms. When you are dependent on your family to get you somewhere it is a particular issue in a rural area because unless you have an organisation that can help you get somewhere and get to things, that is difficult.

I do not want to overcomplicate it. I appreciated the lines of questioning about what is different in rural areas. I think isolation stands out and the transport issues. The lack of local services you can get to under your own steam is the most critical issue.

Karen Black: I echo what Dan said. My area is Bristol, obviously a very densely populated area. I am in North Somerset and we have only been there for about 10 months so we are thinking about how we design services and I think that is the crux of it. It is about the money; it is not enough to get the staffing in to be able to get out there and deliver. The isolation compounds that, and the lack of representation.

There is an issue in our local area around retention and recruitment of staff. That has an impact. There are multiple things. I would not like to argue that they are different, but I think the way that they present is different. For example, if you compare it to inner-city Bristol you have much higher crime rates, gang violence etc. They are different presentations, but it is the isolation that is significant.

Isolation and no infrastructure anywhere around mental health are the things that I would always encourage us to talk about particularly when we are talking about young people. If we constantly talk about young people responding to mental health, we are never going to do anything differently and we are never going to change the long-term outcomes for them. We need to be thinking about all the infrastructure and all the challenges young people face and that is about youth provision meaning they have access to role models if they have domestic violence, poor housing, worklessness, alcoholism, drug use and so on.

While we are continuing to talk about what we should do about mental health, we are not talking about all of the things that influence mental health. Unless we talk collectively about these things with different Departments, for example, we are just going to be in this conversation for ever because we are always going to prioritise the money going into crisis. Of course we are, because those young people are in the greatest distress, but they are always going to be in distress if we do not stop it somewhere over here.

The service design, the isolation and all of those things, and the infrastructure, are what are different when looking at an urban area. I would argue that the issues are the same; they just manifest differently across the two. I hope that makes sense.

Ian Byrne: It does, yes. It is a very good piece of evidence.

Q80 **Rosie Duffield:** I know the answer to this question, but I would like to hear what the witnesses say. In rural areas, what kind of provision is there for the NHS CAMHS service, please?

Dan Mobbs: Yes, you do know the answer. Clearly there is what is available and the difficulties getting to them, but there are also long waits because there is a shortage.

It is also important to mention that CAMHS Services, as they are called—Child and Adolescent Mental Health Services—are doing a lot of heavy lifting for the youth sector. There is this idea that everybody needs to go to CAMHS, but that is not true; it is just that it is all that remains. CAMHS services are not ideal and in the area I live in our trust it is in special measures and has been for some time, despite massive efforts locally to improve things.

Regardless of that, if they are the only show in town to support young people with their mental health, they are never going to meet those needs and nor are they the right places and people to meet those needs. If there are not more preventative services in place, such as youth

work—and it is interesting how many initiatives I see that sound like great new ideas and I think that just sounds like good youth work, it happens all the time—that is the issue.

I feel for CAMHS colleagues. My organisation provides CAMHS services and we are proud of the therapeutic work we offer, but even our therapists are saying they do not want to keep just doing therapy for young people who need groups and activities and opportunities in areas that just simply are not there.

Yes, there are CAMHS services and they do what they can, but there are extraordinary long waits for those services.

Rosie Duffield: In particular your experience will be very similar to Canterbury's in Kent. I know your area very well through my family and I can see a lot of similarities. The last panel said it is about not knowing what services are needed and not signposting those rather than just putting everything into one basket. It also goes back to what Karen was saying about just putting everything together and not talking about what we actually need and not specifying what young people need before it becomes a crisis. Karen, do you want to add anything?

Karen Black: No. I like Dan's analogy that CAMHS is doing the heavy lifting and that is the same in our local area. We have long waits and, like Dan, we deliver CAMHS services and also partner with CAMHS, but there are long wait times. CAMHS has huge issues with staff retention and recruitment as we are seeing at the moment.

It is important to recognise that there is a difference between urban and rural areas. In an urban area you often have maybe more slightly larger organisations that might be working on the periphery of youth work or crossing over. In rural organisations we see very small organisations working in very small communities and they do not have the capacity or the expertise to do really practical things like generate income—more money to build infrastructure—so there is a lack of investment in what is there. Equally, because they are set up as a very local youth club, for example, they have no ability to hold any level of risk, which is what does tend to happen in urban areas. The pressure then mounts up on CAMHS because there is nowhere else to put them.

We have now been in North Somerset for 10 months and we have had about 130 referrals in four months just to our therapies waiting list, and that is with very little advertising and does not include everything else that we are offering. We are now able to offer some first-line intervention as it is called, but the problem is accumulative because CAMHS are under a huge amount of pressure partly because of the way they work and structure things—I heard someone earlier talk about the expectation to go to them—but that is part of the issue of living in a rural area. Getting to places like that is often quite difficult. They do exist, but they are under huge amounts of pressure. There is nowhere to signpost them to so even if young people are there for the right reason, often there is nowhere to go.

Another thing I would like to add to that, and I think Dan touched on it and you may have just touched on it, is that there is something as well around the narrative around CAMHS and mental health and what we think young people need. If I had a magic wand I would wipe clean the slate around how we think about mental health and what we think the answer is. Going back to my previous point, we need to think very broadly. What we see especially in rural areas but we see in our urban services as well is that parents, in particular, think that CAMHS is the answer to their young people's issues so unless they are getting CAMHS they are not getting the service they need in their eyes.

At the moment we are seeing a lot of presentations of young people being stressed about exams, for example, but they do not need therapy for that; what they need is somebody sitting down and talking about revision and timetabling, time planning and things like that. There is a general narrative out there that CAMHS is the answer which then adds to the pressure they are under because anything less than that is not deemed good enough. That is also a challenge that we try to challenge, in that there are alternatives. It is not even just about us, it might be about youth provisions, sports clubs, scouts, anything else that is going to make a person feel better or feel good or connected or whatever it might be.

Q81 **Rosie Duffield:** Thank you. I think that goes back to Dan's first comment; we need to listen to young people; we need to ask them what they need rather than just assuming.

The first part of my question after that has been answered pretty much, but if you could just quickly give us some ideas on this one so we can move on, that would be helpful. How well are the NHS services planned for and delivered to ensure that they really meet the mental health needs of young people living in rural areas? We have gone near to that, but maybe not quite specifically to that question.

Dan Mobbs: I can only talk locally in my area, and funnily enough I do not think the planning of services locally is the biggest problem; we have explored them already.

There are some specific issues around planning in rural areas, as I have said, around the trust going into special measures and with the development of integrated care systems I am unclear how those kinds of things will be resolved in the long run and who makes those decisions.

Planning those services is difficult, but there is very good leadership in how we pull together under what we call the Children and Young People's Alliance and a good understanding of what young people need in communities. It is just that most of the funds for young people's services at the moment are within health so therefore the conversation we have just had arises, that the services become health orientated when what young people need are not necessarily health orientated services but more preventative youth work—all the things we have been saying.

Rosie Duffield: Karen, have you anything to add to that?

Karen Black: Just that the lack of planning is not only of NHS services; it is across the board in many ways. Local authorities have got smaller, CCGs have got smaller and people have broader portfolios of things to look at.

I have been working in and around this field for 20 years now, unfortunately for me to admit, but when I first worked here we had a children's commissioner around drugs and alcohol. I know the times have changed for funding, and I certainly know when we have gone into North Somerset it is kind of, "Here's a pot of money; we need you to deliver services".

We have been really lucky that we have a good reputation locally and we think we know what we are doing so we have been able to create a stable foundation to build upon, but that is luck rather than judgment because we have lost some of that specialist expertise and focus within the local authority and Health. That is not because of the intention of the people who are doing those roles; it is just because the funding pot has become smaller and smaller so the knowledge is not internal any more but sits with us as organisations.

There is a lot of trust there and I know we are quite lucky to be trusted, but I would imagine there are lots of people who are not in that situation, so you could end up with very poorly planned services because you are constantly being reactive as opposed to thinking about what it is you are trying to achieve in the long term. That is hopefully what we are all trying to do, but we do not always have that luxury.

Rosie Duffield: Thank you very much, both of you.

Dan Mobbs: If I could just add, because it has come up a few times and to make the point clear—recruitment and workforce planning is a real difficulty in rural areas for mental health services and youth services. That is something to take away because I have been hearing that from all the other areas as well.

Q82 **Dr Neil Hudson:** We are coming to the end of the panel session for you. Again, I have a question for a wish list. I do not want to take up the next question, which is about service delivery so if you could keep your answer to do with what key things you think would make a difference to improve young people's mental wellbeing in rural areas, what would your wish list be? Keep away from service delivery because I think my colleague is going to cover that in the next part of that question. What things can improve mental wellbeing for our young people in rural areas? If I start with you first, Dan.

Dan Mobbs: I am going to start with where I started the session, with making sure young people have a say over what that is, and that is the starting point—involving young people.

The other thing is that these services need to be youth oriented. For example, the development of family hubs is great, but young people need

something they identify with and that they have agency over because power at that time of your life is really important.

I am unsure if this goes into delivery, but the idea of youth hubs and outreach and groups and activities and being able to get there is a key wish—transportation particularly. I am trying not to go into the next question. I suppose if this is more sort of visioning, I think we are trying to create a community essentially that a young person wants to stay and live in so the answer to the question involves thinking about everything in that community. I think that has already been said; we cannot solve this problem by narrowly focusing on mental health in rural areas.

Dr Neil Hudson: I agree with that.

Dan Mobbs: Yes. You have to look at the community and what makes a good community that someone wants to live in and that includes everything. Thank you.

Karen Black: My wish list would be the same; Dan's last point really. It is about that investment in wider support structures so we then become part of the puzzle rather than the solution, so investment particularly in youth services and various other things around transport and access, something around planning, just that more joined-up planning, asking what it is that we are trying to achieve.

I also think there is something that comes into planning, certainly where we are, that there are two vast disparities, the first being the numbers of young people and old people, so people trying to plan are just stuck in the middle of two very conflicting agendas in many ways. The other disparity we have in North Somerset is the gap between the rich and the poor. Groups of people are focused on incredibly different priorities, and those who have the loudest voice are the ones who have the access to the means.

Going back to Dan's point: it is about listening to young people, to families and finding some way to foster local knowledge because—echoing Dan's point about retention—people wanting to stay in areas has a huge impact on how you deliver services, what you are delivering, what young people have access to. People seem to finish college and then move, stay away and then maybe come back 30 years later.

Q83 **Dr Neil Hudson:** I am going to push you on the points you have both made, and the previous panellists have made, about an understanding and knowledge in the local community. We have talked about prevention rather than crisis management.

Regarding mental wellbeing and young people being aware of what they need to do to try to stay well, can you very quickly give us your thoughts on getting that message into schools, education, about keeping yourselves well, and also mental health first aid in schools? That is not service delivery, Sheryll; this is about prevention. How do we get education and signposting, into schools and how early?

Dan Mobbs: The answer to that is, yes, and as for how, there is a number of ways of doing it but there is a lot of pressure on schools to do a lot of different things they are not necessarily expert in. If you are going to support schools, and school settings are sometimes very challenging for young people to access support through, but education around how to keep yourself safe, the challenge is getting people who are specialists in that area and training them and not expecting the history teacher to suddenly be an expert in mental health and wellbeing. Equally, we have sexual health professionals who go into schools and I would not expect them to teach history either; we need specialist support I think.

Q84 **Dr Neil Hudson:** Again, very quickly, Karen, are you aware of how much of this goes on in rural schools? Could you put that into your answer too?

Karen Black: We are delivering our mental health support teams, which is a relatively new initiative. We are taking that into North Somerset schools and we are being welcomed because schools do see themselves in many ways as wraparounds, although I agree with Dan that a lot is asked of them.

The messaging through schools has been very successful, but the other issue is generational messaging around stigma, isolation and understanding within those smaller communities. How do you get in and challenge that?

In many ways, Covid has helped us think about mental health differently, but we have come out of Covid in many ways and we do need to hold on to some of that learning. It is also about how we support families around young people's mental health and their own mental health as well.

Dr Neil Hudson: Thank you very much. That is very helpful.

Q85 **Mrs Sheryll Murray:** A final question: what change would you like to see in mental health services for young people in rural areas and how they are designed and delivered?

Could I go to you first, Karen, because you mentioned that you have seen differences in the way services are delivered compared with 20 years ago. Do you think advances in technology have filled some of the gaps you identified? Would you answer that first and then go on to the way services should be designed in rural areas and your wish list, please?

Karen Black: Digital and technology have advanced and we have all had to get on board with that in the last two years—I am in Bristol at the moment phoning in, that is novel—and I would also say access to broadband and knowledge of how to use technology has probably advanced more in rural areas, but private spaces for young people to even feel able to access digital technology is a big issue, particularly for young people from, say, LTBTQ plus communities. They do not want to be jumping on to a Zoom call from their bedroom while their parents are downstairs; it does not work. While technology is something we embrace, and it has certainly transformed some of our services, we cannot rely on

it as the solution for multiple reasons. Do you want me to do my little bit of a wish list now?

Q86 **Mrs Sheryll Murray:** If you would. What changes would you like to see in the way mental health services are delivered and designed for young people?

Karen Black: Taking Dan's point, for us, it is always about having young people at the centre. I will always come back to the wider infrastructure. I know the question is about mental health services, but we cannot exist on our own. We are not creating and supporting a healthy future population, future leaders, with our current approach of how we can respond to the mental health crisis as opposed to what can we do to prevent it in the future. For me it is about wider infrastructure, definitely about more investment in youth services, how do we fit into the ICPs. Young people are not really being discussed with us locally and there is an opportunity there to think about local planning and what that means.

I would always encourage people to be brave because if we are not brave we will never do anything differently. The narrative around mental health would help us be able to design services differently. For us, we have a very strong reputation so we can hold our own in the sense of how we think things should be done, but lots of organisations do not have that local privilege, so will often get railroaded to be delivering services that sit alongside or are trying to mirror CAMHS, rather than acknowledging that lots of young people are unique and individual, and we all need something different.

The planning, the infrastructure, the money and the recognition that rural areas are different would be my wish list. It goes on and on, but it is different when you are designing a service. I have not been able to just lift and shift my Bristol service and put it into North Somerset. It would have failed immediately. We are constantly learning and developing, trying to understand how we are reaching young people, because they will not come to this centre point and we may not have the staff to deliver it.

Q87 **Mrs Sheryll Murray:** Before I come to Dan for the final reaction to my question, with regard to schools, in my constituency there is a drop-in centre where young people can consult with somebody and talk things over in a very private way by making appointments, and it is run by a group of volunteers. Clearly, they are qualified volunteers. Do you see a way forward for that set-up so we are not just relying on the NHS or the Government or local authorities for providing all these services?

Karen Black: For me, community empowerment, whether that be local communities or groups of volunteers, would always be something I would advocate for, as long as it is being done safely and has parameters around safeguarding. Charities like us exist to fill gaps, so if there are other ways those gaps can be filled, I would always advocate for those things happening, and also, young people supporting other young people within that context. It is a lot of work to set something like that up and

commitment from people who are volunteers and are often not getting paid for that.

Dan Mobbs: I will respond to that question first. It is important that the panel does not see there are public sector NHS services here that are highly qualified and volunteers over here. It is not like that. We have incredibly well-qualified professionals working with high levels of risk, and it is worth bearing that in mind. For example, eating disorders have increased hugely during the pandemic, as has self-harm, and these presentations are coming to us day-in and day-out. I am sure it is the same for Karen.

The digital question is important. Digital online support is fantastic, but we need to give people choice and we should not insist that you can only have digital access because you live in a rural area. Digital poverty, as has been mentioned, exists in those areas and if you share a bedroom, or you have a small flat and you are working off a tiny phone, it is not okay, it is not private, it is not supportive enough.

I will not say anything too different to Karen. The starting point with young people in rural areas is asking them what they need. In Norfolk we have youth advisory boards and it does two things. It gives young people a platform to have a say over what is important to them in their area, but it does another critical thing. Often, mental health problems are associated with feeling you have no control over your life and you have no future. If we can give opportunities for young people to have a say over what is happening, it is a double whammy. Not only are you getting the services right but you are doing something that helps young people improve their mental health. Any approach to youth provision in an area needs to be that kind of approach.

Yes, you need the CAMHS clinical services and we need to support them, but we also need what I call youth work, groups and activities, mentoring, things that are available in your community, and transport to get around. I do not think it is complicated. Listen to young people, offer some choices in their community, have opportunities for them to move around and meet up with other young people. We should not over-complicate it either, but these resources need to be put into those communities and unfortunately, they have been taken out of them. Listen to young people. They do know what works for them.

Chair: Thank you, Dan, for your experience with young people and also your offer for us to come to Norfolk. We will see what we can do. Thank you for sharing what you are doing and that we need to work out exactly what young people need.

Karen, you talked about the need to be brave, and I think you do need to be brave sometimes to get things to change and move. We appreciate how you are working out from what you were doing more in Bristol and then what you are doing in North Somerset, and how you are seeing a difference between what is happening in the urban part to the rural part. That was very valuable for us, so we appreciate the evidence from both

of you this afternoon. Thank you very much.

Examination of witnesses

Witnesses: Dr Jude McCann and Alicia Chivers.

Q88 **Chair:** I am sorry we are running quite a lot later, but we had the votes and we have also been taking some very good evidence, so we have been trying to get the very best out of everybody. Welcome, Alicia and Dr Jude McCann. Thank you very much for coming. Please introduce yourselves for the record and we will start.

Alicia Chivers: Thank you, Chair. I am Alicia Chivers. I am Chief Executive of RABI. We are a national charity that supports farming people across England and Wales.

Dr McCann: Thank you, Chair. My name is June McCann. I am from a farming family in Northern Ireland and I am now working with the farming community network across England and Wales, supporting farmers and farm family members.

Q89 **Chair:** I come from Somerset and most people would tell that. I think we have a rough idea that you come from Northern Ireland. Welcome to you both. My questions are the same as I have been asking all afternoon. What are the key mental health challenges facing the farming community that your organisations are seeing?

Alicia Chivers: We would reiterate what our previous colleagues have said. The standard rural concerns of isolation and lack of infrastructure absolutely affect the farming community. We have specific challenges; the impact on agriculture and farming people. In the previous panels you heard about the big farming survey and a lot about the stresses, but it is important to reiterate there are very specific situational stresses on farming people, so we are very differentiated from the urban community because realistically, farming happens in rural areas.

Big ones include loss of subsidy—so the BPS transition. We have particularly high inflation. I know that affects the whole country, but we have incredibly high inflation on input costs into farming, and we have regulation compliance, which is incredibly stressful. You have crop and animal health and disease, so there are some very specific situational stresses on mental wellbeing.

The important thing for RABI, particularly from our survey, was the evidence link from mental health to physical health to financial and business health. We have evidence from our farming people, like we are saying, "Talk to the youth about what the youth need". We spoke to farmers and this came back and that gave us that link. There are increasing financial pressures, on top of all these situational challenges,

which indicate to us in all our charities in agriculture that there will be poor mental health.

Q90 **Chair:** To what extent do you find the farming population will tell you when they are that stressed? They are a very traditional community. I am part of it, and they do not like explaining that they have problems. Do you have a code to get through? How does it work?

Alicia Chivers: We find it is about trust, like everything, and that is the same with any community. For us, as a charity, the majority of individuals who are referred or come to us will be on another factor. It will be financial or something practical is happening and they need some other support. As you build up that relationship of trust with the individuals and their families, that is when you start to unpick the mental health, so it is building a relationship and passing across to Jude with his volunteer network.

That is so important and, for us, having this localised network of support is absolutely paramount because it is that network that allows people in a way that is non-threatening to them, to come forward. The other piece is anonymity, so providing an anonymous service.

Q91 **Chair:** It is essential, isn't it?

Alicia Chivers: Absolutely, and particularly for mental health. We recently launched full in-person counselling, availability across England and Wales for agriculture, and it is effectively anonymous. It is name, phone number and broad area, and we are linking up to counselling around one person a day.

Q92 **Chair:** Is that a lot more than usual? What is the situation at the moment?

Alicia Chivers: It is about three or four times our expectation at this level. For a start-up, because you obviously build, and it is looking at where there are models. There is DPJ, who operate in Wales and started this about four or five years ago. Their start rate was much lower than this. There are things we can do to help tackle this.

Dr McCann: Touching on some of the points that Alicia has made, for us in FCN, loneliness and isolation are huge factors. I have spent the last week travelling around Suffolk and Norfolk, meeting with many of our FCN volunteers and farmers, farm families, and the physical isolation in some of our farming communities is huge. Farms have become larger, but smaller in numbers, and as a result more and more people are becoming isolated. Stress and uncertainty were already mentioned. Going through the transition and what lies ahead—there are a lot of farmers who contact us in FCN who are very worried about the future, worried whether their business is viable going forward.

From my personal point of view, my parents and my grandparents were very proud farmers and proud food producers, but I have noticed over the last couple of years with FCN that many people who contact us do not feel valued by society or by the Government. I think that is a huge issue

because we need to change that narrative. We all need to realise we do depend on farmers three times a day—every one of us in society—but few think of it in those terms.

The isolation, the loneliness, the stress, the financial issues around fertiliser costs, fuel costs currently, the pressures mount up on farmers, who are very often operating one-person businesses or small family businesses, so they don't have that support network around them and in many cases are carrying a lot on their own shoulders.

Q93 **Chair:** When I first started farming quite a few years ago, there were many more people coming around the farms to try to sell you things and all sorts of services. Now, it is nice to be able to go online and do things, but you do not see anybody, do you? Are you finding that an issue?

Dr McCann: That is one of the unique things about FCN, in that we have a volunteer network of over 450 volunteers across England and Wales and we will go up and down those farm lanes because sometimes, other than the postman and maybe the vet to livestock farms, there may be no one else visiting those farms.

We will go and sit around the kitchen table, develop that relationship, the trust that Alicia talked about as well. It is only after two or three visits that people start to open up around the mental health issues and the challenges they might experience. It might be an initial phone conversation around TB or other issues, but you don't get to tackle some of those mental health issues, or it does not come up in the conversation until that trust is established.

There is still a macho culture in farming communities, men especially—we don't want to talk about our mental health. Farmers will call a vet when an animal needs attention but are very reluctant to go to their own GP. We need to change that mentality; our physical or mental health is something we all need to look after.

Q94 **Chair:** The hospitals and the doctors always say when a farmer goes in, "You should have come in much sooner". If you cut yourself, you carry on. With mental health that is a similar issue because they will carry on until such time as they cannot carry on any longer. How do you get them to come clean, to admit to what is happening? They are letting the side down, aren't they, at that stage? That is what they feel. How do you get over that sort of stigma?

Dr McCann: In FCN we changed our name a number of years ago from Farm Crisis Network to Farm Community Network. We have taken a much more proactive approach. We want people to come to us with their problems before it becomes a crisis. Our volunteers and staff are doing tremendous work getting out in front of farmers at local marts, agricultural shows, and trying to normalise the conversations around mental health and wellbeing.

We have a long way to go, but we are starting to chip away at some of that stigma. One thing we have seen over the last two years is that the

presenting issues that come through to our helpline have changed quite significantly. It always used to be that financial pressures were the No. 1 issue, but now mental health and wellbeing is the No. 1 presenting issue. There are two sides to that. One aspect is where people are comfortable in talking about health and wellbeing, but also the last two years have put additional pressure, not just on farmers but on all of society, but it is compounded in farming communities because of that isolation.

Q95 **Chair:** RABI is very well-recognised within the farming community. How do you make sure that not only you help but the other farming charities do as well? It is almost a shared responsibility, isn't it?

Alicia Chivers: It absolutely is. Jude has been with FCN a couple of years and I am probably three years into RABI. There are a number of good supportive forums. At the local level there are farmer support groups, and at a national level there are four or five larger charities. We operate at a national level and we are working together.

Our strategy at RABI is about partnership working, so for the mental health services we partner with professionally qualified counselling providers. We call it community pillars—the local peer-to-peer support groups and helping to upskill them. We are working with a lot of those smaller farmer groups to ensure their volunteers and potentially FCN volunteers, as well as our own, have the skills to help normalise the conversation. I am not saying we are never parochial, because we are all charities and organisations in our own right, but we work very hard.

Having been in a number of sectors in charities over 30 years probably now, we are one of the least parochial charitable sectors because we understand fundamentally that we are all supporting that farming person and that is the most important thing. There is not one organisation that can do this and—obviously we are sitting in front of a Committee—I think there is a huge part for Government to play in this as well. How we link that up is something we probably need to think about as a charitable sector—how we engage better with Government.

Q96 **Ian Byrne:** I am reading statistics from your survey and it is devastating. What are some of the key reasons why the incidence of suicide is so high among farmers and what can we do to address it?

Alicia Chivers: We are not a suicide specialist charity, so I don't want to speculate in front of the Committee. We work with and have been collaborating with Rethink and Samaritans. Samaritans have a slightly broader rural campaign on at the moment. As a lay person and non-specialist, it is difficult to unpick the fact that we have quite a high prevalence of men in farming and that tends to be from a suicide point of view.

We also have quite low-paid individuals and, from our forecasting, we currently have a relatively large group of population who live below the relative poverty line. That is likely to impact on suicide figures, and we have quite high levels of depression. All these are potential triggers, and I don't have the experience or knowledge to then say, beyond that,

whether you are on a farm and you deal with life and death and that makes it potentially easier, or you have ropes and guns and the ability geographically to take your life. I don't have the experience to answer that and I will pass over to Jude.

Dr McCann: In FCN we tend not to focus on the statistics around suicide. There is a lot of under-reporting and a lot of unreliable statistics around that so, unfortunately, the problems may be more severe than is reported.

I spent seven years in New Zealand, working with the University of Auckland and the Ministry of Agriculture out there. I interviewed farmers across the country who had been forced out of the industry in the mid-1980s when the Government pulled away all their policies. I also met with many farmers who survived that period of change. Every one of the farmers I spoke to knew of maybe one, two or three suicides in their own local community. It was just devastating at the time in that country.

I think there are undoubtedly huge pressures on farmers. The stigma we have already touched on, and one of the key things we need to think about is: how do we normalise that conversation around mental health? Every one of us in this room has mental health, but we don't think of it in those terms. You hear the term "mental health" and automatically there is a negative connotation to that, so we have a huge piece of work about normalising that, ensuring farming communities are looking out for each other and looking out for their neighbours.

One thing that we have done coming out of Covid-19 is asked our FCN groups across the country to set up reconnecting events. We know there are a lot of very isolated farming families who have either lost loved ones because of Covid-19 or have not had the funerals or wakes they would normally have had. We are trying to get that social aspect returning to the farming community and that is hugely important.

In many places the local post office has gone, the local pub has closed, the opportunity for farming folks to come together is diminishing, unfortunately. We do a lot of work at the agriculture marts because farmers are relaxed in that environment, so to sit down and have a cup of tea with folks and bring the issues around wellbeing into that conversation in a normal context is hugely important.

Q97 **Ian Byrne:** To pick up on a couple of things you said, when you were in New Zealand and the devastating impact of what you outlined, are there any lessons there that were learnt that we can bring over here?

Dr McCann: It was interesting to talk to farmers who survived through that period. Often, I heard the phrase, "It weeded out the weaker guys", so it weeded out the weaker farmers, but the reality of it was, some of the best business people in the farming communities were also forced out.

If you happen to have been carrying debt in the mid-1980s, which the most progressive farmers were, when interest rates went through the

roof in 1984-85, some of the most successful business people were forced out of the industry. That is an important lesson to understand. With the current context of changing policies, transition, high input costs, we could potentially lose some of our best farmers and farming families, and I think that would be a huge shame for England.

Q98 **Ian Byrne:** You say it is a huge problem. Is it down to the likes of yourselves as organisations or should we expect more from the NHS, DEFRA and the Government at large? Should we expect more from them to help communities with the messaging, the youth problem potentially where we are now? I have had a couple of farmers phone me regarding fertiliser prices, everything. You can see on the end of the phone that they are really worried and the fear is palpable. I can imagine that is replicated right across the country. What do we need now to make sure there is an intervention as such?

Chair: Could you refer to the NHS mental services as the next question? Do answer Ian on the rest of his question, please.

Dr McCann: In relation to the NHS, we all know it is under huge pressure One thing from my experience in Northern Ireland—

Q99 **Ian Byrne:** We will answer that with the next one, so steer clear of the NHS. That is my fault. From the Government perspective, DEFRA, getting the message out, more services, we need more.

Dr McCann: We all have a responsibility here. The community and voluntary sector have a very important role to play but we are only one small part of the jigsaw. We need the Department of Health, DEFRA, to be working together to be proactive. We are trying to be proactive in what we do, but we need services to be proactive as well.

Q100 **Mrs Sheryll Murray:** I will ask about the NHS. It is a shame Mr Byrne did not see the question below the one he was asking. How well are rural mental health services planned for and delivered to ensure that they meet the needs of the farming community? Could I ask you, without going into access in particular, is there enough flexibility in the provision, the time to fit in with farmers' working days?

Alicia Chivers: To answer that specific question, no, and that is one of my answers. Looking at individuals contacting RABI mental health services, two-thirds of those are outside office hours and the majority are outside any standard working hours. Farming people don't work office hours, so if the mental health division had been primarily within that timeframe and contacting them within that timeframe, it doesn't work for the community. That is if you can get them over the stigma for this element.

The other piece is about training. I will illustrate it by an example. I want to laugh, but it was absolutely true that our counselling service encouraged the individuals to go to the GP, who then said, "You need to take a couple of weeks off on holiday, off you go". That was a livestock farmer. This was a pure lack of understanding of the situation of the community, and this was a relatively rural GP practice. If there is

training, it does not seem to be reinforced, particularly around mental health, that some of the stock solutions simply are not appropriate for the community they are supporting.

From our point of view, anecdotally, there is a training issue there that probably needs to be addressed. Otherwise, it is reiterating what other colleagues have said about the centralisation of the support, and communities, as we have established, work from a very localised level and quite anonymised. The more we can bring public services into the coffee caravans, we have a fantastic organisation who do a fantastic job in making it non-threatening to talk about your physical and mental health and we tend to introduce mental health through the physical health side. If we can look at how we can potentially integrate that into CCG commissioning and the push-down of service, I think that would be a fantastic step forward.

Q101 **Mrs Sheryll Murray:** Jude, before you add anything, I worked for 21 years as a doctor's receptionist in a rural area, so I completely understand what you are saying. Very often you find some of the farming community is perceived as land-rich and cash-poor, which perhaps sometimes adds pressure. Do you have a comment on that as well? They still have to work unsociable hours and perhaps you could comment on how you think we can address that situation as well.

Dr McCann: To your second question, yes, some farmers have significant assets there. I have been in farm kitchens where there is no food in the fridge, which is hard to believe that, in this day and age, there are farming families struggling with grocery bills.

One of the significant things that I could bring from Northern Ireland was that I worked with the Department of Health, the Department of Agriculture and the Public Health Agency. I sat on the steering committee that established a programme called Farm Families Health Checks, so these were NHS nurses who were in a mobile unit and they went around every market in Northern Ireland, every farm show. The nurses were mostly from farming families, so they could go out, stand outside the van and talk about TB, talk about the weather, talk about the prices, develop that relationship and get farmers to come in to do physical health checks but also, importantly, answer questions around mental health and wellbeing.

Obviously, Northern Ireland has a small geography, but we have a very large farming population, a lot of small family farms. There is something there that could be considered in England, maybe three or four regions across England that bring that service to farmers and make it normal for people to access that. I know of many farmers who have not been to a GP in 20, 30, 40 years and would be very reluctant to do so. If we can engage at that level it would be very useful.

I did see projects in Australia with a similar mobile unit and they had a mental health nurse and a physical health nurse on the same unit, so you went in for 10 minutes for your physical check, and then you spent 10

minutes with the mental health nurse. That is something that we could consider here.

Chair: Some very good stuff there. Rosie, please.

Q102 **Rosie Duffield:** I think we have pretty much covered my question, but you might want to add something else. Are people able to get access to treatment as soon as they need it? Judging by the previous answers it does not sound like it, so do we need to think outside the box?

Alicia Chivers: From our research when we are looking to set up, we have both digital and in-person counselling. There is an average wait for mental health services of between six and 16 months across England for the farming community. It is not a statistic, but that is from our research. I would suggest if it is going to take that period of time we need to think how we can try to address that. There is a certain amount that services such as ours can do to support the interim position, but it is only an interim position. If people need an excessive amount of counselling, it points to the fact that they probably need more significant interventions, and that then ultimately will come down to the NHS because that is the reality of life.

Thinking of other ways around this, we come back in a slightly circular way to how we ensure that we can encourage the provision of mental health services to travel to an extent or be more accessible to the individual, rather than the individual having to access the experts and resource in a central, often urban location.

Dr McCann: The proactive approach that I touched on is something that we need to look at. We are trying to do more awareness and training around looking after your own wellbeing, your resilience. We have a children's book that is very much focused on children in farming families, thinking about resilience. Within that, we have simple things like a joy jar where we encourage the family to put things into the joy jar—what they as a family like to do. That is a smart way of getting the parents to read the stories to the children, but to realise that you need to take time out of your day or your week to spend time with your family, your children, remove yourself from the farm and take that little bit of a break. We know that many farmers work day in, day out, 365 days a year. The only day off may be to the agricultural show. I think we have a bit of a culture change to do around that.

We are trying to do more training to normalise the conversation around coping with stress. Every one of us experiences stress in our lives, and to think about it in terms of your own farming community. If somebody does not turn up to church on a Sunday or the pub on the Friday night, check in with people to make sure they are doing okay and to ask the question twice or three times, "How are things at home?" is important.

If we could bring that about that cultural change where society and Government appreciate what the farming community does for us. I think of the NHS and the heroes that they are—and rightfully so—and have become over the last two years. Given what is going on globally, food

security needs to be higher on the agenda. The environment is very high on the agenda, and rightly so, but I think farming people and rural communities need to be high on the agenda also.

Rosie Duffield: Thanks so much for flagging that, because I know in my community it is just stress after stress and very little thanks and reward. Thank you for highlighting that.

Chair: I think you also are making the point that farmers do believe in producing food—and that is what they primarily do—and they believe in looking after the environment as well, but they see their role as food producers and it does affect their mental state. Thank you, Rosie. Final question, Neil please.

Q103 **Dr Neil Hudson:** Yes, I think that concept of food security and producing food has come into sharp relief during the pandemic. One of the good things that has come out of this horrific pandemic is the concept of keyworkers and that farmers, vets, anyone in the food production line, are keyworkers and they need to be valued in society. That will increase their physical and mental wellbeing as well.

We have covered a lot of the issues that are in this final question, so I will ask this as your wish list, if you can give us very punchy, bullet point answers. What are the key things that you think would make a difference to improve the mental wellbeing of the farming community, Alicia?

Alicia Chivers: A big one for me is communication and language, and I will aim that for this Committee at DEFRA. It comes back to talking about food production. We have pretty much not heard about food production for the last two years from DEFRA. We very rarely hear about the wellbeing of farming people and, even with the Future Farming Resilience funding, it is an add-on. I accept business resilience and funding that is incredibly important, but we are unable to bid solely to support farmer wellbeing in that process. We must piggyback on to another bid, so it is how you communicate.

My second point is to provide as much certainty and control back to the farming person during the transition period as possible. For us, RABI and probably FCN, we support the bottom quartile, the small family farmers, who are less engaged with DEFRA. We believe that a key stressor—and it is going to get worse—is they are starting to understand that subsidies are being withdrawn and their anxiety levels are going up. Between January and March, we have seen a 50% increase in calls to our helpline with concern about this, and they do not understand what the options are for them. I think that probably comes down to communication again.

Thirdly, it is about co-design and partnership working. DEFRA does liaise with us as charity groups, but services do not seem to be gelling together somehow. We need to do more to bring this into focus. We need to think about how we can localise and look at that localisation anonymity of service going forward.

Q104 **Dr Neil Hudson:** That is very helpful. Jude, can you give us a punchy, bullet-point wish list?

Dr McCann: Services need to be designed and delivered by people who are relevant to the farming community and understand the issues in farming communities. In Northern Ireland every policy has been rural-proofed, and that is something that is missing over here. There are a lot of policies being designed without thinking about how it is going to work in rural farming sectors.

Programmes to support may need longer and better resources, so for many of the people we are supporting and interacting with it takes many months of support, sometimes years, to get that individual into a good place. We have found some very vulnerable people who we are supporting. We have managed to get them into the health service and into NHS. Some, unfortunately, have discharged themselves and injured themselves quite seriously. We have also had hospitals contacting us after someone has been discharged, asking us to support an individual they are trying to move out of their system. That is not the role for us as FCN.

Q105 **Dr Neil Hudson:** You are straying into my final question, which is what changes you would like to see in the delivery of the mental health services, but you are answering that there. Would you like some more joined-up approach in terms of a holistic approach for people in the farming and rural communities?

Dr McCann: Yes, it needs to be more holistic and it needs that joined-up approach where the community voluntary sector has an important role to play, but we cannot become the dumping ground from health services that are struggling.

Q106 **Dr Neil Hudson:** We are getting a theme today that the voluntary sector is there, but it should not be relied upon. There are gaps in support, but we need to work together—central Government and local government but also the voluntary sector—to make sure that it is done in a holistic way.

Dr McCann: Absolutely, and when we are dealing with those particularly vulnerable people it is crucial that we do that.

Alicia Chivers: We would very much like to see the role of the third sector in the preventative space. Understanding how we work together to move when that hasn't happened, or we have missed that and someone is in crisis, is then a public requirement. That would again be a step forward.

Dr Neil Hudson: That is another theme that is coming through today, the role of preventative measures that would mitigate having to have so much crisis management. I think that has covered your wish list. Thank you. Back to you, Chair.

Chair: Can I thank you both very much, Alicia and Jude. I think you have highlighted for us the particular pressures on farming, with the changes that are happening, and the way farmers view it. Like I said, they do not like change. They do want to produce food and they do not hear much about it. They see a lot of change around them, but they are isolated and

sometimes the machoism within farming is high. We must make sure that we can break that down in the nicest ways and help people. We appreciate what you all do to help the farming community. Thank you very much.

Examination of witnesses

Witnesses: James Russell and Dr Rosie Allister.

Q107 **Chair:** Thank you very much for being so patient. We very much value your evidence, but we have been voting and each panel has taken slightly longer. We have had some very good evidence this afternoon and are looking forward to some very good evidence from yourselves.

Dr Rosie Allister, would you like to introduce yourself and then James Russell?

Dr Allister: Hello, my name is Dr Rosie Allister. I am the manager of Vetlife Helpline. Vetlife is a charity that is there for the veterinary community. We have a 24-hour telephone and e-mail support service. We offer a professional mental health service and financial support to people in crisis.

James Russell: James Russell, senior vice-president of the British Veterinary Association representing our members across the country. I would like to add that I think that, of all of the sessions that I have been in front of you, this is perhaps the one where I am most likely to stray into some personal thoughts, as well as those that come from the British Veterinary Association.

Q108 **Chair:** Feel free to answer with any personal thoughts that you have, because this is very much about trying to get to grips with what is happening with rural mental health. Please do not hesitate for one moment.

Naturally, we all judge it to some degree from where we are coming from with our own experiences, but we are trying to get to grips with this. My question is the same as it has been to all four panels. What are the key mental health challenges facing people working at this time in the veterinary roles in rural areas that your organisations are seeing? I will start with Rosie.

Dr Allister: I will come in with a quite difficult example of one of the ways. It is something that other people have mentioned this afternoon, but I want to illustrate it with a very real issue for vets. One of the things that we see a lot of is thresholds for mental health care, meaning that people who are in work are very often not seen as unwell enough for help. The challenge that raises specifically for vets, and particularly rural vets, is that rural vets often do not have a choice to go off sick. There is

nobody who can cover their work and they are very committed to their work.

One of the things we see when vets die by suicide is that commonly they die in the workplace after a full day of work. They are seen as not being unwell enough for help when they are in work, but they will never be unwell enough for help.

Q109 **Chair:** Are you seeing that increasingly as a problem?

Dr Allister: The suicide rates in the veterinary profession have been elevated for a long time. We do see real challenges for vets at the moment. Through the pandemic it has been very difficult, with the pressures in rural communities. We have just heard about some of the pressures facing farmers and a lot of those are shared with the veterinary community, with their close working with farmers.

We also find at the moment there are very particular issues facing vets and affecting veterinary mental health. A very significant one is staffing pressure. I have just alluded to directly how that affects people specifically in rural communities, and I know that is your interest. We speak to vets, and we speak to lots of vets in this situation, so this does not identify anybody, who know that they are very physically or mentally unwell and they cannot get anybody to provide for the animals under their care, so they face a very stark choice, and sometimes it is not a choice. They just must keep working.

Those staffing issues, which are acute in the veterinary profession just now, are providing particular challenge for people in rural areas. It is harder to get cover in rural areas than it is in urban areas. Also, we need support for recent graduates. We know that is a particularly difficult time during veterinary careers and can affect mental health. If the staffing is not there that can be particularly acute in rural areas.

There are other issues as well. The issue that you were talking about earlier, of loneliness—staffing challenges intersect hugely with that. We speak to people, and again this is a large number of people, who have not seen their families for several years and that is because they have not been able to get time off work. We speak to people who are in that situation and they say, "I cannot get anybody to cover holiday for me this year." That can be the situation for people in very rural areas and I think a lot of people do not understand that, if you are not speaking to people in very rural areas.

Q110 **Chair:** James, from the BVA point of view, with this isolation of vets, is it more apparent in the smaller practices than the larger practices? Some of the rural practices now are quite big, aren't they? I have several big ones in my own area. I was used to having very often in my younger days a one or two-person practice and there was a lot of stress then. How are you finding it across the BVA?

James Russell: I will take that in the timeline that you have just described. I certainly think that the stresses that we have seen on the

veterinary profession have changed over time. Certainly, if I look back at the named partners of McMurtry and Harding, my old practice, when they founded the practice, it was just the two of them and they worked between them 24 hours a day, seven days a week.

Equally, if I may indulge in a tiny anecdote, I remember hearing of one of the partners being on duty on a Saturday afternoon and answering the phone with, "That sounds an absolute emergency, Mrs Pumphrey, I will see you first thing on Monday morning." I am not saying that is right, I am not saying that is where we want to be as a profession, or where we should be, but it is incredibly different to where we are now.

One of the things that we do see in terms of that increasing size of practice is that we need that, to allow people to have the time out of work, because they are under such pressure when they are in work, particularly when they are on duty.

You asked specifically about rural areas, and to come back to that, one of the things that we recognise is that—as Rosie has alluded to—that period of moving out of college, where you have lived with several of your peers and contemporaries in a relatively sheltered environment, is a vulnerable and challenging time. I can point to several examples of people who have taken their dream job and then found they are an hour from the nearest pub, or two hours from the nearest person who is also in their 20s. They might work in a practice with other people, but they are probably people like me who have kids at home and, quite frankly, want to go home to see their kids at the end of the day rather than going out with colleagues. That creates huge isolation for those young people.

The other thing that we have at that point then in those practices is a group of people who are desperate to care, desperate to support and desperate to help their clients. We have heard it a couple of times this afternoon, about the paucity sometimes of visitors to some of these farms.

Again, I would like to talk about a specific example, if I may, and the example I would like to talk about is John. I used to see John quite frequently and it would not be uncommon to see John on a Thursday afternoon and for him to tell me, "You are the only person I have seen so far this week, James." John got his leg caught in the PTO shaft of his tractor. That obviously was not a mental health crisis, but it was a very significant physical health crisis, and I think exposed to John just how isolated he was, but it also brought home to us the caring responsibility that we have.

Again, and please if I am using too many examples just stop me, Chair, the one that I thought I could perhaps quantify slightly here is the work that I have done through the TB Advisory Service, where I have visited a number of farms, some of which were known to me and some that were not known to me, but roughly 100 across west and north England. Of those 100, three of those farms have ended up with the farmer in tears

around the kitchen table with me. One of them was somebody I knew, and it was about TB, which was why I was there.

In the other two cases, one was going through a divorce and was not sure how they were going to keep the farm. I had never met that person before. Another one had a son who wished to be known as "Sophie" and this farmer did not understand how he was going to manage that change in the relationship with his child. I was the person having just met them who they wanted to talk to about that, because I was the person who was there. When you put that responsibility on to someone who is fresh out of college and is working in these quite isolated ways, going home to an empty flat, we are asking a lot of our professional colleagues. Our nature is to want to support, want to help, want to care. That is why we become vets. We do take a lot of that into ourselves and on ourselves.

Q111 **Chair:** It is an interesting point you make. You are trained to look after animals, but you are almost having to look after people, because you are the people who the farmers see and they probably do not see many others. Then you have the pressure of looking after animals and livestock. What about the big animal side of it? Do you think that is an extra pressure on vets? I am not saying it is all cushy looking after pets, but in the farming profession we are rather inclined to think that. Is it an extra pressure?

James Russell: I need to be careful here, Chair, because I do have a narrative about how brilliant it is to be a farm animal vet. From my perspective, I think you are right and an intersection exists between the pressures of the emotion of caring for animals and caring for families and then as we have heard so powerfully earlier the financial pressures that are being brought to bear. I still know people, both farmers and vets, but farmers in particular on this occasion, who are profoundly affected by what happened to them in 2001 through foot and mouth. Yes, I think that is an important point. I will pass to you, Rosie.

Dr Allister: I absolutely agree with everything that James has said. Disease outbreak is a significant burden on vets psychologically as well as in the support that they provide, if you talk to vets who were involved in the foot and mouth epidemic. The Association of Government Vets did a survey about mental health and wellbeing, and this specifically came up 17 years on, so that was the point of that survey.

Other things that I think are issues for large animal vets is the intersection of physical and mental health. There is a prevalence of injury at work. Injury at work quite often means that you cannot carry on working as a farm animal veterinary surgeon or a large animal veterinary surgeon. This is also a huge issue for equine vets, so physical injury at work is a massive issue.

Then there is isolation and loneliness and people sometimes misconceive loneliness among professionals. They see a professional and think, "They cannot be lonely. They have other colleagues that they talk to", but to not be lonely you need to have enough connection in different dimensions

of your life. It is not just your work; you also need to have contact with family and be part of a community and have other links as well. Quite often veterinary work when it is extreme in its hours can displace those other needs for connection.

Working in very rural areas as a vet you spend a lot of time on your own in a vehicle getting to very remote locations. That can mean the equivalent of lone working for more than half of the day.

Q112 **Dr Neil Hudson:** Before I ask my line of questions, I should declare an interest at this point.

Chair: You probably should, as our resident vet.

Dr Neil Hudson: Yes, as a veterinary surgeon and also prior to entering Parliament, I had a significant involvement in terms of delivery of pastoral care for vet students and also was involved in some research in terms of mental health in the veterinary profession.

Quickly following up on your points about foot and mouth as well, the experiences that I witnessed in 2001 were some of the most distressing and moving experiences in my life and certainly were part of my journey into politics. The memory of foot and mouth, certainly for the veterinary profession but also for the farming community and in my part of the world up in Cumbria, is still very much in people's minds now.

I have a tough question here. What are some of the key reasons for the high incidence of mental health issues but also suicide among the veterinary profession? Could I widen that because I know Rosie has done research on this? This also sadly tips down into the veterinary student body as well so what are some of the key reasons for that? Then what potentially could we do to try to address this? I will start with Rosie.

Dr Allister: I will address the question of suicide first. One of the things that we know is very important in public health in terms of elevated instance of suicide is differential opportunity for suicide, sometimes known as access to means of suicide. Vets have almost unique access to medicines and firearms that are often associated with veterinary suicides. That access is important.

I am involved in some research now looking at what could be done in terms of maintaining animal welfare, the need for access, but also balancing that with risk for individuals and how we can support people and make things safer for everybody. It is not just access to methods. There are other professions that have access to methods but do not have the elevated suicide rates that vets do.

There is a huge amount of occupational stress, for sure. Some of those workplace stresses also feed into whether people can access help, and that is where it starts to cause a bit of an effect. For example, one of the things that we have been talking about in rural communities is the difficulty of asking for help, especially when, as we have just been talking about, vets are seen as supporters. When you are seen as a supporter and you have a particular role and a particular status and you are the one

who helps, it can be very difficult to ask for help yourself. It is not just about people not asking. It is also about people asking and, as I mentioned already in my first example, still not being able to get help even when they desperately need it.

In a survey that looked at vets who had experiences of suicidal behaviour, half of them had not asked for help and that was to do with feelings of burdensomeness, blame, shame—so powerful emotions, things that we know are important in suicide. Also, they worried that if they disclosed it they would face disciplinary action and they would not be able to do their job any more. If, as we have described, you have professionals who are living for their job and their job is a huge part of who they are and a huge part of their life, if they are frightened of losing that they will sometimes continue to risk their lives when they are very unwell.

There are other issues also. One of the risk factors that has become more raised up in awareness in terms of recent years of death by suicide is people who are bereaved by suicide. The veterinary profession is quite interesting in that way, in that if you talk to veterinary professionals, I find it quite unusual to find a vet who does not consider themselves in some way bereaved by suicide. We know colleagues, we know fellow students, we know people who have died by suicide, and sometimes we have workplace contact with people who die by suicide.

I mentioned earlier that vets who die often die at work, and so it sometimes comes upon colleagues to find colleagues who have died at work. That has a huge impact on people both in terms of future potential trauma but also experiencing suicidal thoughts themselves.

Q113 **Dr Neil Hudson:** Could I just push you a bit as well? On the student side of things, some of the research talks about veterinary students as high achievers coming into this environment and then potentially feeling a bit of an imposter. It is quite a levelling experience. I speak from personal experience when you get into vet school, a dedicated group of people coming in, it is quite a stressful degree programme and occupation. What can be done to try to mitigate that?

Dr Allister: This is something that I have looked at in my research, and one of the things that we found about students was that there was sometimes a sense of inevitability, that this might just be something that happened to them as part of their veterinary career. This highlights one of the difficulties of awareness without solution. We hear so much about mental health awareness, but if you just have awareness of mental health and suicide, and you do not have help available, supports and infrastructure, where does that leave people? That is an issue that faces some vet students.

Particularly for students, you mentioned this idea of perfectionism or high achievement. That culture of high achievement is something you see in other students as well, and the difficulty of reconciling that with being a person who needs help. There is a massive piece of work still to be done

about the stigma, the idea that somehow asking for help with a mental health condition is weakness, when it is the absolute opposite. It takes huge courage to ask for help with your mental health.

James Russell: If I can add to that slightly, I should declare an interest here, Neil, as someone who has just started to work with Nottingham vet students as a lecturer there. I think from a BVA point of view we recognise that now is a particularly profound time in terms of the challenge to students' wellbeing.

On that point I do not make a special case, I do not think, for veterinary students, but in a recent survey of veterinary students—Rosie will probably remember the numbers better than I do—I think 75% of our student population were saying that they were concerned about a friend's mental health and about half were concerned about their own. I think that is approximately the right numbers, so just to put an idea of the magnitude of that. That is why we work so closely with brilliant groups such as the Association of Veterinary Students and our Young Vet Network, to make sure that we maintain strong community pastoral and supportive links, with peer-to-peer support in those groups.

Dr Neil Hudson: We are going to come on to support mechanisms later. Sorry to cut you off, but there will be more later on that.

Q114 **Mrs Sheryll Murray:** How well are rural NHS mental health services planned for and delivered to ensure they meet the needs of people working in the veterinary roles?

James Russell: We have heard earlier on about the working hours of farmers, and very similar could be said about the working hours of vets and particularly vets working in rural communities with our farming communities. If you ask, "Can you be here at 10 o'clock on a Tuesday morning?", the answer will be, "Probably not, and, if I could be here at 10 o'clock this Tuesday morning, I might not be able to be here at 10 o'clock next Tuesday morning, especially if we are just going into lambing time," or, "Perhaps I will see you again when my farmer starts silaging". That is approximately where we would be at if we were restricted to the office hours approach to consultations.

Rosie has alluded to the fact that we recognise some of that is about our own members recognising that it is okay to prioritise their own mental wellbeing at that time above the needs of being a vet on call. That is a very tough ask, if you are the person who the farmer is waiting for, to get the calf out of the cow. That is the conflict that we work with through this and the compounder that can be on how you feel about yourself, if you do take time out in order to access those services.

Q115 **Mrs Sheryll Murray:** Those services often are not as regular in a rural area because we have already heard that they are not as prevalent as they are in urban locations, which might add to the pressure.

James Russell: If I may, I live in Kate Griffiths' constituency of Burton, and that is a mixed rural/urban constituency. What I recognise there is

that if you need to access mental or physical health services you are likely to have to attend Burton. If you live in one of our villages or more rurally than the villages, how are you going to get on to public transport? We are in a situation now where even within Burton constituency's second town of Uttoxeter we must arrange volunteer drivers to enable people to get across to Burton Hospital for 9 am appointments, because the public transport links do not exist, and that is from within the town of Uttoxeter.

Q116 **Mrs Sheryll Murray:** Thank you. Rosie, do you have anything to add to that?

Dr Allister: I agree with what James has said. Also, there is a lot of mental health need within the veterinary community. As a charity we provide extra mental healthcare to the veterinary community and, when you look at cases that go through, all of those are people with mental health conditions that most people would expect would be included within health services provision. Those people have not had their needs met, for a variety of reasons. Some of those are to do with things like working patterns, like expectations of work, like the moral injury of having to make a decision about whether you do not work and leave no care in place, no veterinary care for your area, or whether you take time out.

I think there is also an issue about access to the range of mental health needs that people have. Sometimes it seems like there is a focus on mental health need that is very specific around diagnosis. One of the things that we see a real challenge with—particularly in suicide prevention—is you can have people who are suicidal and at great risk who may not fit the exact criteria for a mental health condition. Therefore, they are not eligible for any help, so you have a very suicidal person who is at very high risk and there is no help for them. That is a real challenge, so it is a matter of thinking about needs in terms of real people in rural communities and the needs that they have, not in terms of provision per diagnostic condition.

Q117 **Mrs Sheryll Murray:** I think I know the answer to the second part of my question, because you have probably already answered it, but are people able to get access to treatment as soon as they need it? Do you have some examples you would perhaps like to share with us?

James Russell: I could share one very specific example, Sheryll, if I may, of a parent who reported to me that they attended mental health services with their child, a teenage girl, and were told that the mental health services could recognise why they were there with their child, recognise that there were things that they could do, but recognised also that the pressures on them were so great that they could not intervene at that time. The message that parent came away with was that they should go back when their child was self-harming.

Q118 **Chair:** So the earlier intervention is not there, basically?

James Russell: Can I just say please for the record that that is not a criticism of the people delivering that service?

Q119 **Chair:** Yes, it is just the stress that they were under also.

Dr Allister: Absolutely and this is not a criticism of the people delivering the services either. I think our sense is that it is not about a lack of awareness among the people delivering services, it is not that they do not understand that people are at risk, but just that they have very limited resource and who do they provide it to? Do they provide it to somebody who might be all right, who is still working and they cannot tell because maybe they do not get to know them that well because they do not have the opportunity to, or do they provide it to somebody where there is a huge amount of other concern around that person to do with other services? These decisions are not easy decisions at all.

In terms of examples, I cannot share any examples from Helpline because it is so confidential, however I can say that I have known veterinary professionals who have died by suicide who felt, in the years prior to their death, that they had mental health needs that were unmet, and they died from suicide.

Chair: For the first part of question 14, can I ask Rosie, please, and then the second part Neil?

Q120 **Rosie Duffield:** What are the key things that would make a difference to improving the wellbeing of the veterinary community? I know we are supposed to keep it short, but maybe your key bullet points would help.

James Russell: I am going to answer that, and you will wonder where on earth I am going with this, sorry. A big thing is about community feel and planning laws and the way that planning is carried out in some of our rural communities.

Rosie Duffield: No, I can relate to that.

James Russell: Within the patch where I have worked for the last 18 years it is very easy for my farmers to get planning consent to convert a barn into a holiday home. It is not permissible for them to convert it into somewhere for their adult children to live. Therefore, we see an ageing of the population in our rural communities. Where am I going with that? Of course, where I am going is where I started, which is that social network, the young farmers' groups and so on, that young vets can join in with, can feel part of the community that they are there to serve, and can feel supported within that community.

Dr Allister: For me it is similar. It is something that requires a lot of understanding of rural communities, which is that services come and work with people who have a very strong sense of self-reliance, who find it not just difficult to ask for help but find it difficult to work with services and difficult to access them for lots of reasons. I think support for people who are in work is also important, because as I have said, with vets and veterinary nurses, they will often be in work until the day they die, so it is very important that they have support while they are in work.

I would also say valuing veterinary communities and valuing farming communities is important. That sense of being valued is incredibly

important when you are doing difficult and stressful work and sometimes physically dangerous work. When you do not feel valued and you are doing that work it is very difficult.

Rosie Duffield: Thank you. I think those of us who are working with rural communities recognise that the NFU does such a great job of bringing those people who are on outlying farms and smallholdings together and having that cup of tea and that focus, and certainly inviting MPs for tea goes down very well. Thank you both, and thanks, Chair.

Q121 **Chair:** Before I bring in Neil for the last part, do you find perhaps as a veterinary community that farmers will look up to vets and see you as a beacon of being able to solve their problems? Does that put more stress back on your veterinarians because they have that extra pressure? Would that be fair to say? I know we like to complain about the high bills you charge us, but in the end we have a lot of respect for the veterinary profession.

Dr Allister: It is a huge privilege of vets and vets will tell you that their relationships with clients, particularly farmers, are a huge part of the meaning of veterinary work and the importance. I think a lot of people who do not understand veterinary work think it is about animals. It is very much about people and supporting communities and being part of that community and being part of food production in farming.

It is a huge privilege, but along with that supporting role—and that very much is a role that people describe having—it is important to understand what those people need when they need help. That is often a very high degree of confidentiality and sometimes even being able to have a choice about services. Do they go to the service that is in their village, or do they go to a service in a nearby town where not so many people know them? Having those choices is important to people. It is a meaningful choice as well.

One of the things that we hear a lot from vets is being excluded for lots of reasons from help that seems available. One thing that I would say about helping rural communities, because we know that people already find it hard to ask for help, is making sure that that help does not have exclusions, that it is genuinely there for everybody in that community.

James Russell: First, the offer to go in the smaller of my two jets remains open, Neil. Obviously, I realise we are all rolling around in money, us vets. Seriously, the only thing I would add to what Rosie has said is that so much of the way that we are trained and so much of the way that we deliver our day-to-day work is as problem solvers. Therefore, when we come up against a problem that we find harder to solve, like what is up with this person today who is in front of me, we do feel that responsibility. I would find it very hard to answer how much of that is put upon us by our clients and how much of it we develop for ourselves, but I absolutely recognise what you describe.

Chair: Between the farming community and yourself you pass your problems in a way from one to another to a degree. It is almost a shared

problem that we must sort, so I think it is interesting where the evidence is taking us. Neil, over to you for the final part.

Q122 **Dr Neil Hudson:** Before I ask that final question, I want to come back if I may, Chair. James, you mentioned things like TB and foot and mouth, and thinking about some of the stressors on mental health for both the veterinary profession and the farming communities, we in our previous inquiries have been looking very closely at the situation facing the pig sector in terms of healthy pigs being slaughtered on farm and not going into the food supply chain, and how devastating that is for the farmers and vets involved.

With that in mind, the pressures of that, I am leading the witness here a bit, but thinking about disease outbreaks, farmers waiting for TB tests, vets involved in that side of things, could you articulate to the Committee some of the pressures affected by the peculiar, unique things that happen in the rural veterinary world in terms of disease outbreaks, culls and that side of things? Can you articulate that, because I think that would be powerful evidence for us to take away for our report? James, do you want to start?

James Russell: You are absolutely right; TB testing is a seriously stressful time for many people. Someone reported to me just recently that during the reading of a TB test a shotgun appeared and it was not being pointed at the vet. To be working under that pressure as both a vet and a farmer is incredibly tough.

Where we are now, we know we are in the biggest disease outbreak that the country has seen since the 2001 foot and mouth outbreak in terms of the avian influenza outbreak. I have not been directly involved on-farm but I have heard the tales of people who are unable to move healthy birds from unrestricted units because they would have to travel through an AI restriction zone. What that does to you, when your life's work is to assemble food for people's plates, is something that we should not understate.

If I may, Neil, and I am sorry it is slightly tangential to the question you have asked me, but I see that we have a crisis coming down the track at us very quickly. We heard earlier about the price of fertiliser, and you think, "Okay, well, the price of fertiliser", but I was on a farm the other day and this farmer had filled an entire shed with fertiliser that he had been able to buy at £200 per tonne. He had just been offered £1,000 per tonne to sell it. That fertiliser is not going on to land in the way that it has done in the past. That means there is going to be less food coming off the land next year.

We must recognise that in the same way that we talk about moral injury in the veterinary profession for feeling unable to provide the treatment that we want to provide, this is the profession, this is the life's work of these farmers, and they are going to, I think, feel that they are unable to provide in the same way in coming years. I see that spilling over into the veterinary profession as well. Disease outbreaks, but also ability to

produce food security, all those topics, are coming together to put pressures on both communities almost without a margin between them.

Q123 **Dr Neil Hudson:** Thank you. That is very powerful testimony. Rosie, do you have anything to add?

Dr Allister: Yes. Something somebody said to me recently, and it was not on Helpline, so I can speak about it, was about the avian influenza outbreak. It reminded me a lot of what people have said about foot and mouth and other outbreaks over time, which was that they do not know when it is going to end, and that is how desperate they feel.

I think it embodies in a way that phrase, the amount of effort that vets will put in during an outbreak. In terms of vets who are very involved in that work or are very affected by it, they will go to huge lengths and work incredible hours, and give so much of themselves, yet it is completely out of their control in many ways. Along with that, there is just not an understanding among broader communities outside of rural spaces, where people understand what is going on. If you asked a lot of people on the street, not everyone would know about these issues, and that does affect the way that people feel when they are working to that degree and there is no end in sight, and they do not know when it is going to finish. It is an incredible stress on people.

We should value people who do those exceptionally difficult roles, at exceptionally difficult times, when they do not know when outbreaks are coming, and the rest of their life does not always allow for those things either. People miss major life events, parents' funerals, all kinds of things because of disease outbreaks. People do not always understand that and have a very superficial understanding of how disease outbreaks happen and work.

Dr Neil Hudson: Thank you. Finally, Chair, I will get on to the question now.

Chair: Please do.

Q124 **Dr Neil Hudson:** You are both involved in some of the service provision through Vetlife and the Royal College of Veterinary Surgeons' Mind Matters Initiative. What changes would you like to see in the way mental health services are designed and delivered to meet the needs of the veterinary community? Who wants to go first on that?

Chair: Rosie is bursting.

Dr Allister: Support for people who are in work, that takes account that people need to stay in work sometimes, that people might not have a choice about not working. Also, flexibility in how and where people attend, so a choice for people so that people can choose whether to be seen locally or further away, whatever is right for them. Care for people who are suicidal, not based around diagnosis, but if you are suicidal and you present to health services a guarantee that there will be help. That is important. Also, support for people who are bereaved by suicide and joined up physical and mental healthcare. When you look at referrals

through our mental health service, most people also have physical health conditions, often related to things to do with work that are concurrent with mental health difficulties, and the separation of those does not help.

James Russell: I will not repeat all the bits that Rosie has said, but what I will add, if I may, is something that I feel passionately about. We risk falling into a trap of considering rural vets and our farming communities as a homogenous block and we describe what "their" needs are. I think we need to recognise that we have a community here made up of a range of people, but I would add that what is also true of our rural communities is that there is perhaps less exposure to some of the changes that are happening in a more urban society. That can lead to a feeling that perhaps we are one or two steps behind in terms of attitudes and acceptance of and appreciation of differences in society.

The bit that I would add is support and development of initiatives that enable greater understanding and greater acceptance of a broader range of our society, because I absolutely recognise an additional pressure, which Rosie and I have not added in to this discussion yet today. It is the intersection between being isolated and experiencing a degree of prejudice in the community in which you are working. I would like to see us taking some steps to improve that.

Chair: I want to thank Andy very much here on my right for putting together four very good panels and some very good questions and the work that he has put into it, and I want to thank all members for their support here this afternoon. We took longer.

I want to thank Rosie and James for a complementary session and how it has all come together. It has been a very moving afternoon for all of us. I do appreciate the genuine evidence that you have given us, and I think all four panels have given us a lot, but yourselves very much so.

What you have also highlighted for us is the link between farming, the veterinary community and the rural community. and that is so important. Thank you very much. I am sorry it has taken a little bit longer, but then I do not apologise for taking a bit longer, because I think we did have the vote in between and what I think we have fairly done is allowed every panel to go over time. I think we have treated you fairly in that respect and we have used our time very wisely this afternoon. It has been a very good session. Thank you very much.